CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

APPLICATION FOR RESIDENTS, INTERNS, AND FELLOWS APPLYING FOR LICENSURE IN DELAWARE

Return the completed application along with a **$14.00** check or money order made payable to the State of Delaware.

NAME IN FULL: _____
LAST FIRST MI

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____/_____/_____
MM/DD/YY

NAME AND LOCATION OF MEDICAL SCHOOL AND DATE OF GRADUATION:
(Attach a copy of diploma received. If school is located outside the United States, attach a copy of ECFMG Certificate.

_____
NAME OF MEDICAL SCHOOL DATE OF GRADUATION

_____
ADDRESS CITY STATE ZIP CODE

NAME AND LOCATION OF INSTITUTION WHERE TRAINING IS TO BE CONDUCTED:

_____
NAME OF INSTITUTION DEPARTMENT PHONE #

_____
ADDRESS CITY STATE ZIP CODE

DATE TRAINING IS TO BEGIN: _____

1. Have you ever taken any of these examinations administered by the USMLE, FLEX, National Board, or State Boards? ( ) Yes ( ) No If yes, provide location:

   _____ Date _____

2. Have you ever failed a licensing exam? ( ) Yes ( ) No If yes, provide details:_____

   _____

3. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? If yes, submit a certified copy of your criminal history record. ( ) Yes ( ) No

4. Have you ever been convicted of violating the Medical or Osteopathic Practice Act of another state? ( ) Yes ( ) No

5. Have you ever engaged in the practice of medicine or osteopathy without a license? ( ) Yes ( ) No

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 *Del. C.* §8735(m). It may be used to enforce child support obligation pursuant to 13 *Del. C.* §2216 and for other lawful purposes.

6. Have you ever been refused a narcotic license or had such license modified, suspended, canceled, or prescribed narcotic drugs unlawfully? ( ) Yes ( ) No

7. Have you ever willfully violated the confidence of a patient? ( ) Yes ( ) No

8. Have you ever been convicted of fraud? ( ) Yes ( ) No

9. Are you now, or have you ever been dependent upon the use of alcohol, stimulants, or habit-forming drugs or been treated or disciplined for their use? ( ) Yes ( ) No

10. Are you physically and mentally capable of engaging in the practice of medicine according to generally accepted standards, and would you submit to such an examination as the Board may deem necessary to determine your capability? ( ) Yes ( ) No

11. Have you had either a mental or physical illness which interfered with your practice for over a month? ( ) Yes ( ) No

12. Have you ever had a medical or osteopathic license denied, revoked, suspended, or limited or placed under probation? ( ) Yes ( ) No

13. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, or the Drug Enforcement Agency of the Department of Justice or a State's Narcotic Agency in this country or any other country? ( ) Yes ( ) No

14. Have you ever had a disciplinary action taken against you by a Medical or Osteopathic Society? ( ) Yes ( ) No

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15. Have you ever had a change in hospital privileges as a result of a disciplinary action taken by a hospital? ( ) Yes ( ) No

16. Has a settlement ever been made or a verdict rendered against you in a malpractice action? ( ) Yes ( ) No

17. Are there any charges pending or are you under investigation regarding a felony or misdemeanor or unprofessional conduct, or professional misconduct, or malpractice? ( ) Yes ( ) No

18. Have you ever been granted a medical licensure by a State or Territory? ( ) Yes ( ) No If yes, please indicate the state or territory below:

State or Territory	License Number	Effective Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF YOU RESPONDED "YES" TO ANY QUESTIONS NUMBERED 1 THROUGH 18, (*WITH THE EXCEPTION OF QUESTION NUMBER 10*), EXPLAIN THE CIRCUMSTANCES AND THE FINAL DISPOSITION ON A SEPARATE SHEET OF PAPER.

Please note: When your application is complete, please allow 4-8 weeks to receive your license. A complete application is one that includes all required documentation and correct payment.

THIS SECTION IS TO BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC BY THE DIRECTOR OF THE TRAINING PROGRAM OF THE INSTITUTION WHERE THE APPLICANT IS TO BE EMPLOYED.

_____ _____

Printed First and Last Name of Resident/Intern/Fellow Signature of Resident/Intern/Fellow

I verify that the above-named Resident/Intern/Fellow will be participating in a training program located at:

_____ beginning _____ and that his/her

NAME OF INSTITUTION MM/DD/YY

credentials have been reviewed and approved. This physician will be participating in this training program under the supervision of a fully licensed physician in the State of Delaware.

_____ _____

Printed First and Last Name of the Director of the Training Program Delaware Physician License Number

_____

Signature of the Director of the Training Program Date

NOTARY PUBLIC

State of_____, County of _____

Sworn and subscribed before me this _____ day of _____ 20_____.

_____

Notary Public

SEAL

_____

Commission Expires

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THE PHYSICIAN NAMED BELOW WILL ACCEPT RESPONSIBILITY FOR THE PRACTICE OF MEDICINE AND SURGERY OF THIS APPLICANT IN THIS INSTITUTION.

_____ _____

Printed First and Last Name of Supervising Physician Delaware Physician License Number

_____

Signature of Supervising Physician Date